Michigan Department of Community Health

Recovery Council Meeting
Friday, July 18, 2008
10:00 am – 3:00 pm
The Guidance Center
13111 Allen Road, Southgate 48195

Meeting Minutes

I. Welcome – Irene Kazieczko
II. Introduction/Announcements/Share Recovery Stories
    a. Recovery Council Members
        i. Nancy Auger, David Friday, Stephen Batson, Joel Berman, Gerald Butler, Risa Coleman, Patti Cosens, Norm DeLise, Jean Dukarski, Mary Beth Evans, Cheryl Flowers, Annette Grenier, Andria Jackson, Colleen Jasper, Amelia Johnson, Irene Kazieczko, Tammy Lademer, Claudette Jefferson, Marlene Lawrence, Rue Morad, Fran New, Brenda Nyhof-Dunn, Donna Orrin, Greg Paffhouse, Marty Raaymakers, Sherri Rushman, Leslie Sladek, Kathleen Tynes, Dennis Urbanczyk, and Pam Werner.
    b. Recovery Council Partners
        i. Kendra Binkley, Valarie Bishop, Marci Cameron, Karen Cashen, Jay Cohen, Darryl Cornwell, Sue Eby, Deb Freed, Michael Jennings, Robert Case, Su Min Oh, Lucy Olson, Alyson Rush, Felicia Simpson, Candace Loughrige, Margaret Stooksberry, James Wargel, Melissa Kruse, Rich Casteels, Stephanie Harris, Kari Walker, Sherry Solomon, Keith Jones, and Ken Sanderson.
    c. Announcements
        i. Annette - Good news, she has been accepted into LPN school.
        ii. Greg Paffhouse – Reinforce the power of your voice. A peer accompanies him to meetings with County Commisioners and leaders of the community. The peer shares his or her recovery story. The response has been powerful.
        iii. Marty Raaymakers – NAMI mission statement has been changed to reflect more current values. She thanks people for their input through the years.
        iv. Nancy Auger – Has just completed her final requirement in obtaining her bachelor's degree in social work.

III. Approval of February 4, 2008 Meeting Minutes
    a. Motion for approval, seconded, minutes are approved.

IV. Mike Head – Newly Appointed Director of the Mental Health and Substance Abuse Administration, Department of Community Health
    a. Introduces himself and tells a little about himself.

b. Recovery and the Michigan Mental Health System.
c. MDCH Perspective.
d. Some Priorities
    i. Mental Health Commission Report Follow-Up.
    ii. Assure equality and fairness in access to services across CMH.
    iii. Assure quality in state facilities.
    iv. Expand consumer and advocate participation in system development.
    v. Assure consumer-controlled support options through self-determination.
    vi. Expand employment support.
    vii. Assure access to health care for individuals with chronic and ongoing mental health support needs.
e. Questions for Mike
    i. Marty- Asks how much of a chance realistically do we have to actually change the culture in jails/prisons? Discussion followed surrounding this topic.
    ii. Marty – Says that Medicare parity just got signed into law at the federal level and she has a request to have someone from the state at the next meeting to talk about spend downs.
    iii. Tammy – Asks about having performance benchmarks for employment directly specific to Peer Support Specialists being employed at lower wages at CMHs. Mike says yes this is an issue; it's hard to talk about because there isn't a lot we can do about it at the state level. He supports the issue being raised and understands the importance this is for peer specialists. Additional comments on agency health care in addition to salaries is discussed.
    iv. Kathleen – what about back when people developed grants and created peer jobs and as people left they didn't fill these positions. Mike says local advocacy needs to address this.
    v. Joel – last 8 months in and out of receiving hospital. Coordination of care is very important. Talked about going in to the hospital to get healed physically but then you are set back mentally. Integration of care with medical doctors is very important.
    vi. Colleen – thinking about trauma stats and the high percentage of people with mental illness with trauma in their past. This is important.
    vii. Stephen – Peer Support Specialist's salaries are not set by the market, they are set by the PIHP. He has been looking across the state at wages, and there is a huge disparity across the state. We are paying peers in Detroit about as much as a grocery bagger. Asked Michael Head to support the continuation of policy as a memo or letter to PIHPs reflecting the state's values and opinions about wages. Mike says he can look into sending out a paper, but he can't tell a CMH how to set their wages.

1. Marty says we are asking the national board of NAMI to take this on. Thinks this may be a good place to start. Won't be a change that happens fast.
2. Mike says we can take this on as a discussion and show the value of Peer Support Specialists. Convince Boards how they can save money and increase outcomes through peer support.

V. Peer Whole Health Initiative – Pam Werner, Marlene Lawrence and Jean Dukarski
    a. Michigan picked as a part of a 3 State Study (Other states are Massachusetts and Georgia). with the Appalachian Consulting Group.
    b. Pilot and roll out in Battle Creek. Research site is Share Center.
    c. Peer to Peer Wellness kit. This is integrated health care.
    d. This is a great avenue for self determination.
    e. Pam – 398 Certified Peer Support Specialists now in the State. 4 more trainings scheduled this year.
    f. Marlene Lawrence, Director of the Share Center Drop-In Center
        i. Morbidity and Mortality Report
            1. Points out the first sentence in the Executive Summary, "People with serious mental illness die, on average, 25 years earlier than the general population. State studies document recent increases in the death rates over those previously reported." She wants to point out the words "recent increases."
            2. She says this is shocking and scary and wonders why people aren't talking more about this?
            3. Our morbidity and mortality are largely related to preventable conditions, such as diabetes and cardiovascular disease.
            4. Higher rates of modifiable risk factors, such as smoking and alcohol consumption.
            5. The Impact of Medications – using second and third generation medications. This study does not prove a direct cause and effect, but Marlene believes when the next study comes out, it will show a direct cause and effect.
            6. Access to Health Care
                a. In addition to getting access to health care, the doctors aren't talking to each other.
            7. She added a column to the study "what should I do"? She says she is going to take this report with her when she sees her doctor. Deserve to know more about the side effects of the medications.
            8. We need to do more at drop-in centers in terms of wellness and health programs.

9. Proud that her state, the state of Michigan, provided funding to the Appalachian Consulting Group to address the morbidity and mortality issues facing people with mental illness.
10. Thought it was great to hear Mike Head challenge and expect us to insert ourselves.
11. Commitment in this room and commitment from the state - we can address the system.

ii. Jean Dukarski, Justice in Mental Health Organization (JIMHO)

1. 4 folks from JIMHO that went to the 3-day training in Battle Creek. Started asking the questions - What do we want to see in a health self-help group? What do you need to address your health and wellness goal? Found out that we all have the same things that allow us to cheat. Found ways to help each other stay on track.
2. Worksheet we do with everyone each week. In addition to that there is an activity that they do every week as well. Not until week 6 that you actually decide what your specific goal is.
3. This gives people a place to start, and they find support and encouragement in the group.
4. Areas that are explored during the weeks:
    a. Exploring your area of dissatisfaction.
    b. Creating the life you want.
    c. Clarify problem behaviors.
    d. Stages of Change.
    e. Goal-setting support systems.
5. Health and Wellness Packs
    a. One for every recovery council member. Have relaxation/mediation CDs, quotes, notebook (sheet for goals to be included in their person-centered plans).
6. Gerald – vital that you, as a Peer Support Specialist, are the person telling us about this. Peers will be more willing to trust and believe another peer.

VI. Discussion of May 16 Town Hall Meeting

a. Dennis Urbanczyk - Project Coordinator and Stephanie Harris
    i. Town Hall Meeting feedback - please send to Stephanie Harris at sharris@iamtgc.net.
    ii. Marketing plan feedback - please send to Dennis at durbanczyk@iamtgc.net.
b. Feedback from Recovery Council
    i. Norm – having been involved in video conferencing for a number of years, it worked very well.

ii. Leslie – lives in a rural area and her computer is old and she only has dial up (high speed is not available) so she and others in this situation can't access the video conference.
iii. Darryl – was at a satellite site, LCC, questions being sent and would have liked to know if they were getting through to you. Some sort of response so that we know you are getting them.
iv. Jean – some sort of auto response letting people know you received the e-mail.
v. Randy – the grant money that was obtained – how does this trickle down to Peer Support Specialists? Rich says they are going to hire some more peers.
vi. Please send any comments to Dennis or Stephanie.

VII. Overview of Michigan Recovery Center of Excellence Marketing and Communication Plan
a. Dennis – excited to be a part of the Recovery Council.
b. Kathleen Tynes – please refer to us as Peer Support Specialists throughout the document. Joel – but don't leave out the Peers who are not certified yet. So, have both in the language.
c. Joel - should be clear about what specific group of people you are talking about. There are Certified Peer Support Specialists, and there are people working and providing peer support that haven't been through the training or certification.
d. Deb Freed – Has lots of suggestions.
i. Step back, look at goals and objectives and have them flushed out a little bit more. Suggests working with the Michigan Association of Community Mental Health Board's (MACMHBs) PR group. Recommends more linkage to the CMH system. PR group at MACMHB has been working with MDCH on Anti Stigma. Have clear links to MACMHB that we are working together.
ii. Goals and Objectives – be clear on your website page regarding what are the goals and objectives. What are the expected outcomes? What are you trying to accomplish with the RCE? More specific about who your target audience is and the goals specific to them. Example – colleges/universities are a target audience and what goals and objectives are related to them.
e. Marty – requests that we have recovery stories up there quickly. Pam says what do you think about having a day for people to come and tell their stories and be taped. Marty and other Council members feel this is a great idea and that it should be acted on quickly.
f. Leslie – those of us with dial up can't look at videos, so we need it written down.
g. Leslie – in talking points, under first bullet point, she would like to see language like "promote recovery to independence and not having to be involved with the system, not have to report our income, not have to be

dependent" added in here. Also, include self-determination in the statewide newsletter.

h. Leslie – in regards to the Speakers Bureau – wonderful idea but need an agenda on who this will include and what goals you seek to accomplish. Make sure website addresses providers as well.
i. Marty – in regards to the Speakers Bureau - concerned about travel and how are we going to reimburse people for their time?
j. Jean – what kind of efforts have been made to solicit information from consumers? What do they want? Rich – that's exactly what this marketing plan is about. Jean - how are you going to be asking people? Rich – phoning, emailing, and visiting people at drop-in centers and stakeholder groups. Survey on website.
k. Stephanie – take a look at the website - there is a survey that people can take. She walked through the survey. Invite others to take the survey in addition to Recovery Council members.
l. Dennis – talked to people via the phone. He also e-mailed CEOs of providers, Drop-in Executive Directors, Peer Support Specialists, Recovery Coordinators, Clubhouses. Most people are interested in whom we are and what we are doing, looking for work, and information about recovery groups.
m. Gerald – most people in clubhouses and drop-in centers are not familiar with how to use a computer or how to use a mouse. Dennis says they have another survey that is going out to clubhouses asking questions about computer use.
n. Leslie – how are we outreaching to areas that don't have drop-in centers and clubhouses? Dennis – we contact the CMHs. Leslie – a lot of times, this doesn't trickle down to the consumers. Need to brainstorm on how to better reach the consumers.
o. Joel – clubhouses are a small part of the population.
p. Irene – this is a draft of the marketing plan and we want to collect all the comments that we can. Please provide them. Perhaps we can collect information at the consumer conference next week. Some comments we can act on immediately.
q. Lucy Olson – perhaps have kiosk machines in areas (like reception areas) that can gather information.
r. Greg Paffhouse – every one in the room represents a group, joint responsibility on our parts to help you gather the information as well. What can we do to help?
s. Jean – consider setting up some sort of advisory committee?
t. Tammy – appreciates the passion of the Council. Recovery stories – that's where the power is.
u. Kathleen – shared her resource list including information for people who are LGBT.
v. Sherri Solomon - would like the practical tool of the RCE information survey printed out and a volunteer can then enter the information.

w. Greg – suggestion to put a budget with the marketing plan. How are you going to fund things like the Speakers Bureau?
x. Cheryl – Native American communities – when people use the public health system, we need people to be knowledgeable about our culture. Has to be a way to include the Native American communities. Important to have people in an agency that can communicate with us.
y. Randy – getting more consumers involved with the website.

VIII. Colleen – Call for Help
a. Asking for volunteers who are interested in reviewing the materials and products that are out there and may be unique to CMHs but could benefit the whole system.
b. Connect with the Center of Excellence on sharing this material and utilizing it.
c. Irene – We would also hope to provide some guidance to people on how to use information consistent with the values and missions of the Recovery Council and Michigan Department of Community Health.
d. Volunteers to be on this committee: Kendra Binkley, Joel Berman, Tammy Lademer, Kathleen Tynes, Margaret Stookesberry, Leslie Sladek, Randy Meyers, Steve Batson, Amelia Johnson, Norm Delisle, Pam Werner and Jean Dukarski.

IX. MDCH Program Planning Guidelines (PPG) requirements policy for systems transformation to a recovery-based system of care using Recovery Enhancing Environment (REE) Scale
a. Technical support and assistance with Advocates for Human Potential
i. Darby Penny
b. Workgroup - Quality improvement approach, measure of where every CMH is at a point in time so we can see changes in growth and recovery. The goal is to have one measure that is used everywhere. Workgroup has developed a plan on how CMHs would submit this information.
c. Kathleen – summarizes what the workgroup has accomplished. The short form is the best form to work with at this time. Trying to get page 10 and 11 of long form included (special needs), will be on the internet, how will agency develop a plan for implementation, selecting accurate representation from areas. We want to make sure we are going with something that is recovery-based, and the OQ 45.2 is not recovery-based.

X. Presentation of REE State Implementation Plan, Darby Penny, AHP
a. Short form consists of:
i. Demographic information.
ii. Involvement in the recovery process.
iii. Elements of recovery and recovery enhancing program.
iv. Individual recovery markers.
b. Project Goals

i. Develop basic knowledge of recovery elements among stakeholders.
ii. Strengthen recovery-oriented practices.
iii. Assess extent of recovery.
iv. Gather baseline data to measure progress over time.
v. Provide summary data to support QI process and policy development.

c. Plan to Implement REE FY 08-09
   i. In each CMHSP and provider agency.
   ii. With representative samples in selected program types in each CMHSP.

d. Program Types to be Surveyed
   i. ACT
   ii. TCM
   iii. C Drop In
   iv. Supported Employment
   v. Medication Clinics
   vi. Crisis Settings
   vii. Group Homes
   viii. Joel says he doesn't see Jail Diversion on this list.
   ix. Rue – many programs would fit under social rehabilitation, and jail diversion would fit under there too. Dual Diagnosis groups.
   x. Greg – are you going to define these programs a bit? It would be helpful to do this. Irene says we are going to use the Encounter Codes that the department already uses.
   xi. Alyson – Please include the age group of older adults as discussed at previous Recovery Council meeting. Darby says yes we are going to add this in.
   xii. Amelia Johnson – didn't really want to be a part of the implementation of the OQ 45 at her agency but was chosen to. They gave each of them a PDA that they carry around and are supposed to ask questions every time they see consumers.
      1. She asks - are you doing a pilot of the REE? Irene says no we are not.
      2. Darby says the REE survey is a point in time survey, and we won't be asking people questions over and over again.
   xiii. This survey will be at the program level.

e. Questions
   i. Leslie - Period of 10 months – why? Her concern is that agencies have a lot of other surveys that they do. Everyone does different surveys at different times of the year. The state should think about this and not over-burden people. Darby - there is not time to do a pilot project. If you roll it out in a small amount of CMHs for a period of time, then it does serve as a pilot project.
   ii. Jean asks can the surveyors be employees of the CMH that they are surveying. Or what about people who are receiving services - can

they administer the survey to other people at that CMH? How will consumer surveyors be paid? Kathleen – we have talked about this but haven't got it all worked out yet. Talked about having consumers go from one CMH to another and get paid for travel.

1. Irene – it is the intent of the department to use mental health block grant dollars for the completion of the REE.

iii. Val – If it is going to be responsibility of each CMH, then is training going to be administered? Different results if people aren't trained on how you want it to go. Darby says yes people will be trained on how to administer the survey.
iv. Joel – technical comment – clubhouse where people who know me and trust me - why shouldn't I be able to survey them. Darby – conflict of interest issues. Need general rules to avoid conflict of interest. Need people who can do it not just in one setting but can also administer it in clinics and other programs.
v. Leslie – suggestion is to look to the CILs.
vi. Dennis - he has been involved with administering many surveys and there is a general rule about interviewing and that is that you shouldn't know the person that you are interviewing because it can skew the data.
vii. Gerald – many times consumers will say that they didn't answer the question honestly because of fear of retaliation.
viii. Mike – the issue is that person is knowledgeable about the survey and trained to administer it and that he or she doesn't know the person that is taking the survey.
ix. Margaret - the trained administrators need to tell people in a positive way that this is about recovery.
x. Gerald – please stress that this is developed by a consumer and administered by consumers. Vital that it is administered by consumers and people don't feel threatened or fear of retaliation.
xi. Fran New - What will outcomes be used for? Darby - data will be anonymously reported. Data will be compared across the system. She isn't sure how it will be shared. Useful for the CMH internally to look at areas where they are low. Help the department at the state level in policy development.

1. Margaret says it will tell us if recovery is happening and it will develop a baseline for what programs it is happening in and what ones is it not happening - how we are going to get there.

xii. Dennis – you really have to sell surveys. Have to mention not only the author but the questions are derived from people in recovery.
xiii. Does this survey transfer over to the VA system? Darby says yes it can be used in the VA system.

f. Irene summarizes
   i. Consensus on using the short form with addition of pages 10 and 11 from long form.

ii. Concerns about who can implement it.
iii. She thanks Darby for her presentation.
iv. Irene thanks the Council and the workgroup for the hard work. She invites more members to be involved in the workgroup. Joel says he would like to join this workgroup.
v. E-mail additional comments to Irene.
vi. Roll out date – want to include it in PPG so August/September.
vii. Jean says some CMHs are saying the OQ 45 is a requirement. Wants clarification. Irene says that the OQ 45.2 is not a requirement - people can choose to participate or not.

g. Marty – move to support the proposal that the workgroup has developed, Norm seconds it. Vote - Unanimous decision for approval.
h. Irene thanks everyone for their participation.

XI. Next meeting is September 19, 2008 at LCC West Campus in Lansing from 10:00 am – 3:00 pm.